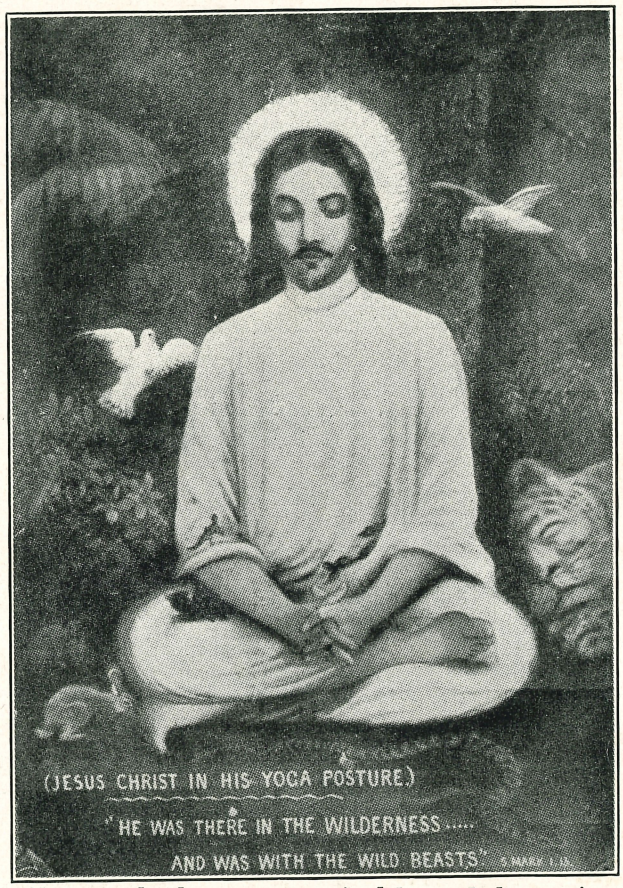
The MEDICAL MISSIONARY



Christ in the desert, as conceived by an Indian artist

Vol. III APRIL, 1930 No. 7

The MEDICAL MISSIONARY

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Editor: Dr. Anna Dengel

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HAPPY EASTER

Recently a hospital Sister heard in a lecture about India, that many women there wear rings in their noses; it made a great impression on her and she asked herself why God in His goodness had placed her in a country where she need not be encumbered with jewelry in her olfactory organ. This seems a trifling thing, however, when compared with the big things in life, such as our Faith and the joy that comes to every child of Our Holy Mother the Church, if her life is lived and followed throughout the year. What Catholic, for instance, does not thrill at the sound of Easter bells, and feels rejuvenated and remade, resurrected, so to say, on Easter morn, hearing the Alleluia. Alleluia is the note of joy and hope; suffering and death, yes, they are common to all the inhabitants of this little planet of ours but the Alleluia has not reached to the uttermost ends of the earth yet, or at least not to every creature, which is perhaps more correct to say, because now there are hardly any more uttermost ends of the earth.

The Alleluia is the expression of victory of Our Savior, the Hope of our life. May it ring joyfully in the ears of all our readers. May it make them feel the happiness of understanding it and may it arouse in them a desire, a zeal to make it resound from pole to pole. This is our sincere and heartfelt Easter wish to all our friends and benefactors.

OUR MEDICAL MISSION CONTEST OFFERED TO HIGH SCHOOLS AND COLLEGES

In answer to the desire expressed by Our Holy Father to our Missionaries to foster public interest in Medical Missions we are sponsoring a Medical Mission Contest.

A friend of Medical Missions is offering two first prizes of $25 each, and two second prizes of $15 each, to College and High School students respectively, to be awarded for the best answers to the following questions:

1. Why is the care of the sick and afflicted a necessary part of Mission work?
2. In what does the work of a Medical Missionary consist?
3. What phase of Medical Mission work appeals to you the most and why?
4. Approximately how many Catholic Mission doctors are there in the field, and how many Protestants?
5. What is the nature and purpose of the Society of Catholic Medical Missionaries of Brookland, Washington, D. C.?

Conditions of the Contest

Any College or High School student is eligible. The answers must not exceed 1000 words in all and be typed or neatly written on one side of the paper only.

The answers must be in not later than May 10, 1930.

Three Missionaries will be the Judges.

The results will be made known the week of May 18, 1930.

The Contest should be addressed to Dr. Anna Dengel, Catholic Medical Mission House, Brookland, Washington, D. C., MARKED CONTEST.

Bibliography for Contest

1. The Medical Missionary, a monthly periodical, published at the Catholic Medical House, Brookland, Washington, D. C.
2. Catholic Missions, official organ of the Propagation of the Faith, especially March, 1930, which is a Medical Mission number.
3. Medical Missions, published by the Medical Mission Board, 25 West Broadway, New York.

The Students of any High School or College who have not received the announcement of the contest by mail are also cordially invited to participate.

FACTS ABOUT LEPROSY

The lepers are waiting in the wild,
Sick and weary and defiled.

The number of lepers in the world is roughly estimated at three millions. All classes of society, rich and poor, educated and uneducated, old and young, are represented among them. The poor are by far the most numerous; undernourishment, lack of sanitary dwellings, overcrowding being factors which favor the spread of the disease.

Many people still think that leprosy is incurable; even most lepers consider themselves doomed. It is this very hopelessness which was the most depressing feature of the affliction in the past.

With the progress of Medical Science it is possible to convert leper asylums from places of segregation to places of treatment and the old idea: "Get rid of the leper," is slowly being converted into: "Get rid of leprosy."

Is there a cure?

Leprosy is a disease which excites public interest as no other disease does. Various contradictory reports have appeared in the press of late years with regard to the curability of leprosy and the possibility of its eradication.

Leprosy resembles tuberculosis in being caused by an organism which has the power of hiding itself away in the tissues of the body like a seed falling into the crevice of a dry rock, ready to germinate if and when circumstances become favorable for germination. For everyone who becomes a leper, there are many who are infected with leprosy, but in whom the disease either never develops or never reaches a stage sufficient to cause trouble.

In the treatment of leprosy the wholehearted, confident cooperation of the patient is necessary. There is no absolute specific drug which will ensure the recovery of the careless, indifferent or despairing patient. But given ordinary favorable circumstances, a patient determined to get better, and a doctor who understands his work and is willing to take trouble, there are few cases in which all active signs of leprosy cannot be stamped out. Naturally, the earlier the treatment is begun, the sooner will recovery take place. The treatment now available brings the disease, which is no longer considered an irremovable infirmity, within the scope of the physician.

With leprosy looked upon as hopeless, so that even in the earliest stages the leper was abhorred and looked upon as unfit for human society, the unfortunate sufferer naturally concealed his inability as long as possible, fear, shame and mental depression impairing his general health and leading to the more rapid development of symptoms. Now considered remediable, he seeks the physician as soon as possible and in the great majority of cases recovers completely. The enlightened employer no longer dismisses the employe in the early infectious stage, but has him put under treatment and asks for reports as to his progress and fitness for work. The effect of treatment of early cases is to prevent them going on to the later and more infectious stages and thereby also lessens the spread of the disease.

There is no infallible cure for leprosy and probably never will be, but there is something which is possibly better, for side by side with the eradication of this scourge there must be sanitary and social reform and it is the fear of such diseases that has always been and will always be the great lever to raise standards. An infallible cure would remove the disease without changing living conditions.

Present Day Methods of Treating Leprosy.

The ideal treatment for leprosy should satisfy the following points: (1) A drug which rapidly controls and eliminates the disease; (2) One which is cheap; and (3) One which is painless. (4) It should be easy to administer so that semi-trained assistants can give it. It can be said at the outset that no drug which is in use at present satisfies these criteria. Among the drugs which approach nearest to the ideal are the following:

(1) Hydnocarpus oil and 4 percent Creosote.
(2) Alepol (sodium hydnocarpate).
(3) Potassium Iodide.

Hydnocarpus Oil and Creosote.

This remedy gives the most uniformly good results of all the drugs used in leprosy treatment. This remedy is easily administered by subcutaneous infiltration, or intramuscularly. It is also generally successful although the time taken to clear up an advance case will be considerable. At the outset of treatment it is unwise to make any statement as to how long it will take before a patient becomes symptom free. Few, if any, cases of leprosy clear up in three months, and many will take anything up to three years or more before it is safe for them to stop treatment. It is dangerous to make generalizations with regard to leprosy, but it can be said that provided care is given to the clearing up of predisposing diseases and all conditions which are likely to reduce the patient's resistance, e. g., the lack of proper food and exercise, then hydnocarpus oil and creosote will be found to be eminently satisfactory in the majority of cases.

Alepol.

In countries where hydnocarpus oil cannot be obtained, alepol is used. It is made up in powder form and is very cheap. When a large number of lepers are to be treated, the latter item is an important consideration.

Potassium Iodide.

In early and specially selected cases this drug is sometimes rapid in its results.

There are many other drugs used in the treatment of leprosy with varying results. It is generally recognized that the building up of the resistance of the body and any measures that do this are of great value.

Is Leprosy an infectious or contagious disease?

Leprosy, a disease that has afflicted mankind for thousands of years, found in all tropical countries and in many others, is caused by a bacillus discovered in 1874, by Hansen of Norway. In ancient times already leprosy was considered infectious; in the middle ages it was held to be contagious which, of course, led people to take proper precautions, which eventually helped to stamp out the disease in England and other parts of Europe.

There is abundant evidence to show that leprosy is spread from the infected to the healthy by direct contagion and that children are more liable to infection than adults. While children removed from infectious parents at birth practically never develop the disease, those brought up by a highly infectious mother seldom escape infection, a whole family of five or six children acquiring the disease from a parent or elder brother or sister. Forty to 50 percent of children are said to acquire the disease if not removed from leprous parents. If this is so, probably 100 percent are infected in some instances, i. e., when parents are highly infectious; as a certain proportion of the parents are not infectious at all, and this number has to be deducted.

The factors which determine the chance of infection are:

(a) The closeness of contact. Progressively dangerous we have: village infection, house infection, room infection, bed infection. The closer the contact the more likely is the disease to be transmitted.

(b) The length of contact: the longer the contact the more likely is leprosy to be acquired.

(c) The infectiousness of the leper; in certain types, stages and phases of the disease leprosy is much more infectious than in others.

(d) The general resistance of the person in contact. This is a very important factor that has not been sufficiently realized in the past. Condemned criminals have been inoculated with suspensions of human tissues containing large numbers of Hansen's bacilli and some of these have failed to develop leprosy. It has been argued from this that leprosy is not spread by direct inoculation. The probable explanation is either that the particular bacilli inoculated were dead or, what is more likely, that the resistance of those inoculated was sufficient to prevent the development of the disease.

In what stages, types and phases is leprosy most infectious?

Another very important point to be considered is the relative infectiousness of the various types, stages and phases of leprosy. Without going into details of the pathology of leprosy it is sufficient to give a brief sketch of the course of the disease.

Leprosy can generally be diagnosed with certainty from clinical signs long before it is possible to find Hansen's bacilli in smears or sections. The lesions first noticed are chiefly skin patches which vary from a quarter of an inch to several inches in diameter when first noticed and may be depigmented and whitish or erythematous. They generally show keratosis, stunting or destruction of hair, and anhydrosis. They show various changes in sensation such as deep analgesia, loss of heat and cold sensation, paraesthesia and loss of epicritic sensation or superficial anaesthesia. The more marked the last symptom is, the greater is the thickening of the sensory nerve branches supplying the area and the less chance is there of finding Hansen's bacilli in the lesion.

Occasionally the first early sign of leprosy is thickening of nerve trunks without any apparent corresponding skin lesions.

In the second stage in a typical case of leprosy bacilli can be found in ever increasing numbers, until a smear taken from any skin lesion or from the mucous membrane of the nose contains millions of acid-fast bacilli in every field of the slide.

In the third stage the bacilli begin to diminish again, leaving deformities of the hands, feet and face.

What are the best means to be taken in a country like India to prevent the spread of infection?

Dr. Muir, the famous leprosy research worker says: "My experience leads me to adopt as perfectly safe the rule that the line of isolation be drawn not between the clinically positive and the clinically negative, but between the bacteriologically positive and the bacteriologically negative cases.

If some such classification were generally accepted and acted upon it would tend to have three effects:

(1) Employers would be more insistent on medical examinations of their employes with a view of finding out if leprosy is present or not.

(2) Employes would come forward more readily for diagnosis and treatment and not try to hide their lesions as long as possible for fear of losing their employment. Thereby they would ensure their own recovery, being treated early in the highly remediable stage; and the danger of the spread of infection to their fellow workers would be lessened.

(3) The fear of the danger of losing their employment would act as an incentive to the patients to do their utmost to get better quickly, a very important factor in speeding up improvement.

The present indiscriminating ostracism of all cases of leprosy which still holds good in some quarters, has the opposite effects, patients doing their utmost to remain concealed. Such concealed lepers are often, it is easily understood, the most dangerous of all infection carriers.

Is leprosy hereditary?

Leprosy is not hereditary. That is an accepted fact today. The children of leper parents, even where both the parents may have the disease in an advanced stage, are born healthy, that is to say, free from infection. If they can be taken away from contact with their leper parents or relatives, and brought up in healthy surroundings they will almost certainly grow up healthy, like ordinary children. Hundreds and hundreds of children have been saved from becoming lepers, in India especially, by being cared for in special homes for untainted children (under The Mission to Lepers).

While this is true it must be emphasized that little children are specially susceptible to contagion, and the majority of lepers contract the disease before they are 20 years of age.

Who helps the lepers?

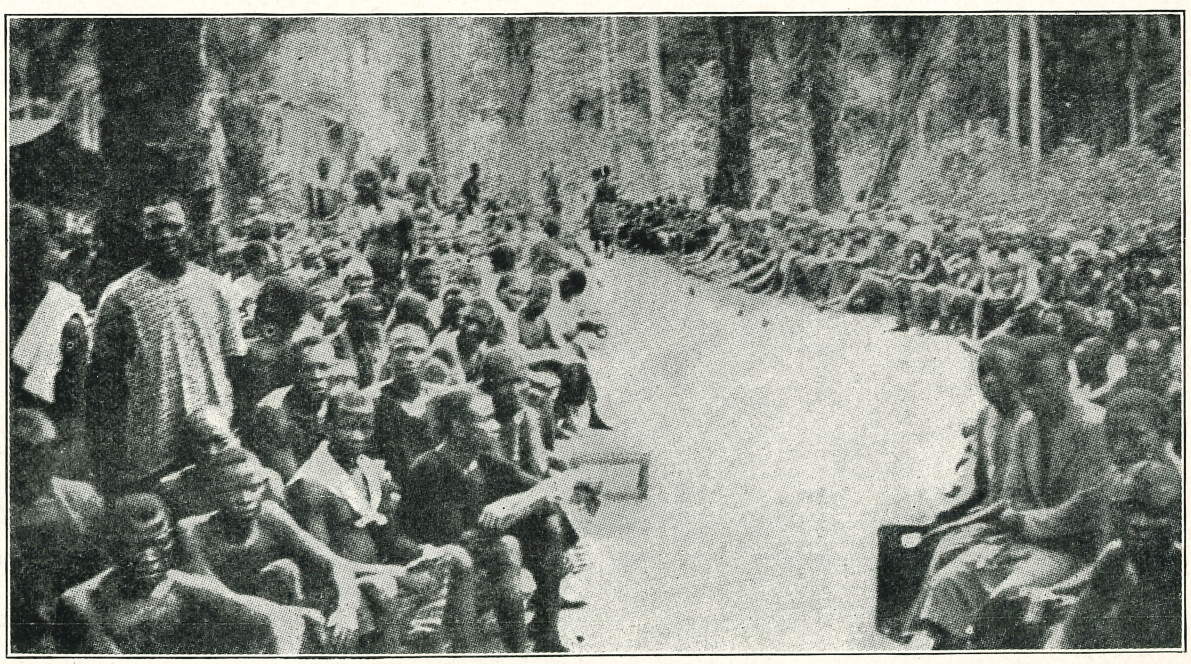
The majority of lepers are not helped yet. Those cared for and treated are taken care of, in some instances, by the government of the respective country, but mostly by missionaries, men and women of different denominations. Leprosy as a disease is greatly feared and motives more deep than can be expected of a purely official organization are required to make a real success of leper homes and colonies.

Sisters of different Orders as is well known, care for many lepers in India, Burma, China, Africa and other mission countries. On account of the growing need for trained workers among lepers, the Society of Catholic Medical Missionaries also hopes to undertake this great work of charity when a sufficient number of volunteers are available.

Many Protestant mission organizations do splendid work among the lepers; and organizations at home do their best to speed the day to rid the world of leprosy. The British Leprosy Relief Association gives financial assistance to leper work without distinction of the denomination by which it is conducted. It also publishes a quarterly magazine entitled, *"Leprosy Review,"* (29 Dorset Square, London, N. W. I.). These brief notes have been compiled by the Editor from it and also from some articles by Dr. E. Muir, which appeared recently in the *"Indian Medical Gazette."*

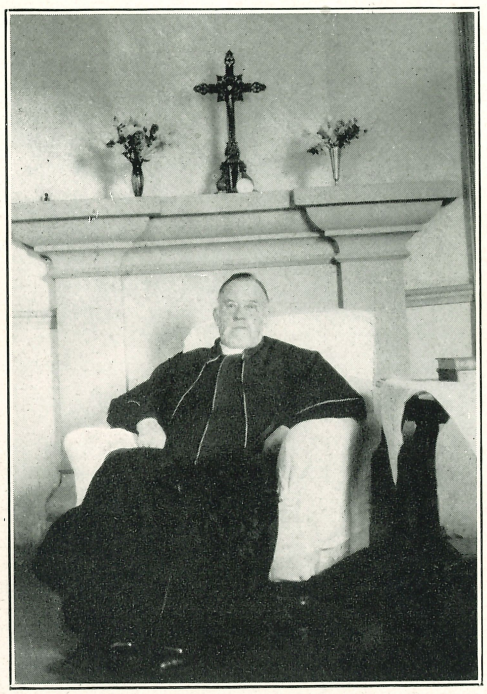
There is a large bibliography on Leprosy available. On request we shall gladly send it to anyone interested.

The purpose of the Society of Catholic Medical Missionaries is to bring medical aid, no disease or condition being excepted, to Christians and non-Christians in foreign mission countries, and thus by Christian charity contribute to win souls to Christ. For further information write to Dr. Anna Dengel, Catholic Medical Mission House, Brookland, Washington, D. C., U. S. A.

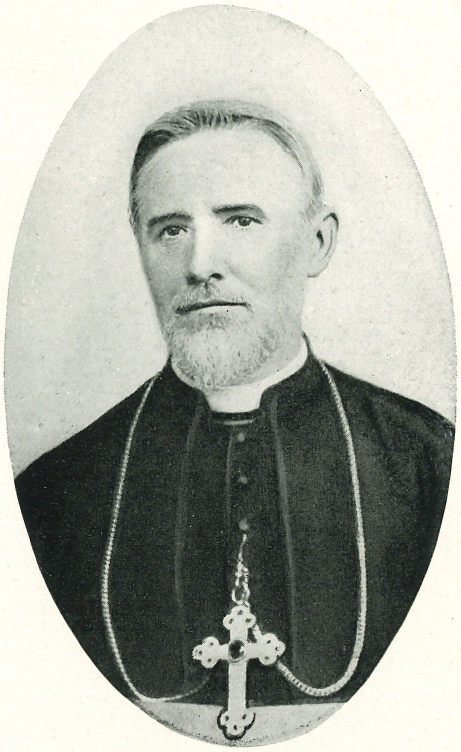


Lepers waiting for treatment at ITU (Nigeria)
(From Leprosy Notes)

THE SOCIETY AT HOME AND ABROAD



Rt. Rev. R. Winkley, Mill Hill, Prefect Apostolic of Kashmir and Kafristan, who has been a missionary in the North of India for 35 years. He built several churches and schools and was also the architect of our hospital in Rawalpindi. Last year he was a patient in it for three months. We are happy to say that after leaving, he was able to resume his work.



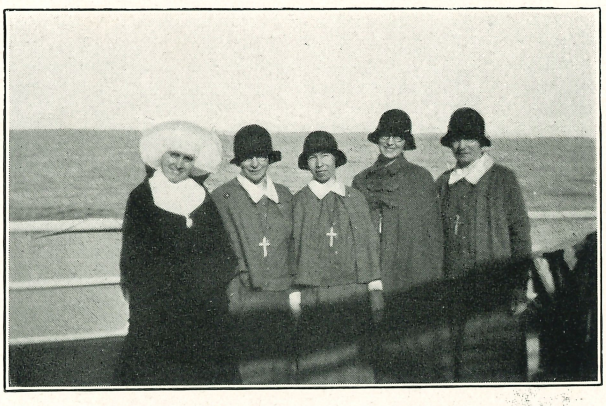
Rt. Rev. Timothy Crowley, C.S.C., Bishop of Dacca, Bengal, in whose diocese we started our second mission on St. Patrick's Day of this year.

NEWS FROM OUR MISSIONARIES

Our four missionaries arrived safely at their respective destination after a very interesting journey, which was full of events but fortunately pleasant ones. After the audience with the Holy Father, they remained a few days in Rome and visited many Churches and venerated several relics, the True Cross, Thorns from Our Lord's Crown, the arm of St. Francis Xavier and others. They also climbed the Holy Stairs on their knees, as it is customary. On leaving Rome, Rev. Father Doheny, C. S. C., presented each of our missionaries with a relic of the Little Flower, which they appreciated very much. They all agreed that it was a wonderful experience to visit Rome. They embarked from Naples on an Italian liner. In Bombay they were met by the Franciscan Missionaries of Mary, whose hospitality they enjoyed for a few days during which they visited some of the hospitals of Bombay, which they admired very much both for management and cleanliness. We did not hear much of their debut in Rawalpindi yet, except that Sister M. Frances is in charge of the dispensary and Sister M. Therese of the inpatients. It will take some time before Dr. Finnigan can make the dental clinic a-go.

Dacca: On the feast of St. Patrick, Sister M. Laetitia and Sister Helen started the Maternity and Child Welfare Center in Dacca, Bengal. Bishop Crowley kindly donated the altar and made it possible for them to have the Blessed Sacrament from the very start for which we are especially grateful. The new mission is dedicated to St. Michael. We hope that under his powerful protection our Sisters will be able to do much good.

At the invitation of Rev. Michael J. Ready, Director of the Propagation of the Faith of Cleveland; of Rev. H. S. Gabel, Diocesan Director of Toledo, and Rt. Rev. J. J. Hunt, Diocesan Director of Detroit, Dr. Dengel spent several weeks in the respective dioceses giving talks on Medical Mission work in High Schools and Colleges, Catholic Hospitals and to Women's organizations. Everywhere she met with much interest and kindness which was very much appreciated and will always be remembered gratefully.



Our missionaries nearing the shores of India, the land of their desire.

Address of our missionaries in **The Punjab:** Holy Family Hospital, Rawalpindi, Punjab, India. **In Bengal:** Ramna Station, Dacca, Bengal, India.

MISSION NOTES

ACCORDING to recent statistics there are 226 doctors laboring in Catholic mission medical institutions and 855 trained nurses.

FIFTY YEARS OF ACHIEVEMENT

One million eight hundred and twenty-two thousand patients have been treated during the past 50 years in the Catholic Hospital of Hankow, Hupeh, China, which lately celebrated its golden jubilee. Founded by the Canossian Sisters in 1879, in two one-room bungalows, the institution has grown until today it occupies a full square block with a capacity of 180 beds, with construction in progress for 30 more. Modern in every detail, the institution contains five fully equipped operating theatres, laboratory, confinement quarters, X-ray, etc., etc., and a large roof garden for natural sunlight treatment. The director, Father Colomban Clement, was recently nominated a Chevalier of the Order of Leopold by King Albert of Belgium.

NEW CATHOLIC MISSION HOSPITAL PLANNED

Catholic Hospital at Kothamangalam.—The Archbishop of Ernakulam, (India), whose Home for the Aged at Chunangannely, near Alwaye, is doing splendid work, has now instituted a new Catholic hospital. At Kothamangalam, near Moovatupusha, a plot of 40 acres has been walled round and necessary buildings put up to serve as the beginning of a hospital, where all classes and castes of patients will be treated by Catholic medical officers, and nursed by Catholic nuns, recruited and trained for the purpose. The need of such hospitals is felt in many centers, and His Grace's example may move some of the wealthier parishes to do more than at present for the sick, the aged, orphans, etc.—*Bombay Examiner.*

PRIVATE NURSING IN SOUTH AFRICA

Thirty years ago nursing in South Africa was in its infancy; very few trained nurses were available for private work and those barely made their living. Conditions have now greatly improved, private nursing is a certainty of earning a living, but it is a life of hard work. It differs in South Africa from elsewhere, inasmuch as that patients are of widely different classes. Money is more plentiful now and consequently the private nurse is in greater demand, especially amongst Jewish families. Nursing in the outlying districts is very difficult on account of the lack of water, adequate appliances and sanitation.

IN CHINA

A rather depressing picture of private nursing in China was given by Agnes B. Chan, superintendent of nurses, Wesleyan Hospital, Fatshan Tung, China, at the last International Convention of Nurses. According to her report, private nursing in China as a whole does not yet exist, the reason being that hygiene is not generally known. The causes of disease and, therefore, the means of preventing and treating it, are not yet known by the majority. What China needs most is an adequate medical profession, better housing conditions and education in matters of health among the people themselves. When some of this spade work has been accomplished the demand for nurses in the homes of the sick has to be created.

A new Congregation of Catholic nuns who intend to devote themselves to missionary work among the Moslem people of the Holy Land, has been started at Jerusalem.

M. K. GANDHI—"Hindu culture has erred on the side of excessive subordination of the wife to the husband, and has insisted on the complete merging of the wife in the husband. The remedy lies through the true education of women as distinguished from unmarried girls, and through cultivating public opinion against unmanly conduct on the part of husbands."

ASK AND YOU SHALL RECEIVE

We wish to thank our friends particularly for their generous response to our appeal for trees, shrubs and seeds. Trees, we had to buy, but rose bushes, other ornamental bushes and many flower and vegetable seeds were sent to us. Very many thanks to each and every thoughtful donor for the contribution to our garden "to be."

When friends tell you that it makes them happy to help the Medical Mission Cause in any way, one gets bolder and bolder. Dear Reader, you would never guess what we would like very much to get. Four fire extinguishers and a big safe to keep our documents and other valuables. Don't think that we are planning on having a fire or that we are getting rich, but living in frame houses, not connected with the city main and quite a distance from the Brookland fire department, we were advised to take all precautions, which is only ordinary prudence.

Making an appeal of this kind is like shooting in the dark, it is very unlikely that any of our readers should have fire extinguishers or a safe to dispose of, but one never knows one's luck.

Promote Medical Missions by spreading THE MEDICAL MISSIONARY. Address: Brookland, Washington, D. C. Subscription, $1 a year.

(*Continued from page 8*)

This time we said we would be back in time for the dispensary patients. All went well to the sixth milestone, when Joseph developed some internal disorder and his respirations ceased. But we didn't mind, we knew how to fix him this time and we did fix him but unhappily, in restoring a nut to its place we twisted off a bit of casting so that a steady drip of gasoline began to come out of the tank and there was nobody for miles about who could do anything about motors. I tried catching the gasoline in a teacup, but without enthusiasm. There was nothing for it but to foot it back to Khaur leaving Sister Agnes Marie to mind the car. And I did and it was a glorious walk, six miles to the edge of the town and one to the office.

Sister Agnes Marie caught up on her prayers and admired the view for an hour or so until another good Samaritan hove into sight driving a car, one of the American drillers who had helped us with a contribution the day before. He stopped, of course, viewed the trouble and inquired if we had any chewing gum. By great wonder and good fortune we had in our basket a couple of sticks of spearmint that had arrived two days before in a Christmas box sent by a hospital Sister at home. Little did she know what a good deed she did in sending us gum. The gum was produced and the Samaritan fell to chewing it. When it was the proper consistency he bound up the wound of Joseph with it and a bit of bandage which happened to be in the car. The leakage of gasoline was stopped and Joseph happily proceeded back to Khaur where he met me just setting out with reinforcements to tow him in. Then, without a single cough or snort, on 53 miles to Pindi, where his appearance at the garage caused some amusement, as you may suppose. It was the end of a perfect two days.

A BEGGING EXPEDITION IN INDIA

A TALE OF OIL AND CHEWING GUM

By JOANNA LYONS, M. D.

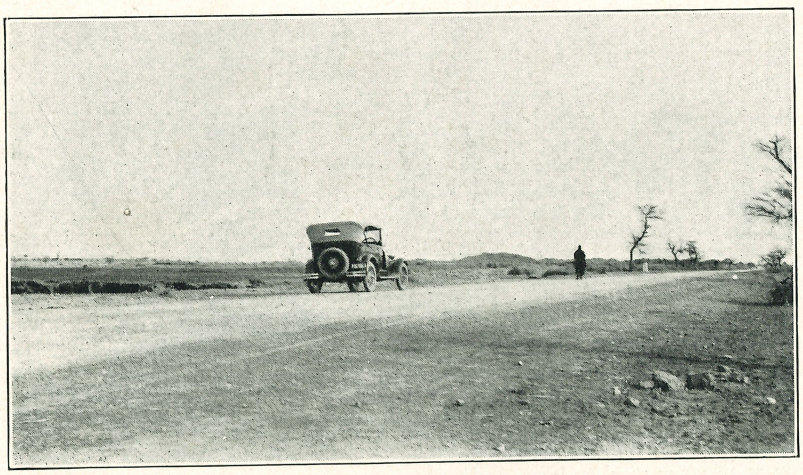
IN picturing to oneself the likely activities of a missionary, that of collecting money probably does not readily come to mind, unless said missionary be in the homeland and then, as everybody knows, he or she is dangerous to meet. Having come to this side of the world said missionary is considered to figure chiefly as beggee rather than beggar. But there are exceptions. Wolves come to doors here, also, and must sometimes be appeased by the passing of the hat.

Such an emergency arose at our hospital lately and with it the recollection that 50 odd miles from here is an oil field, and at that field is a colony of American drillers. So we put two and two together and decided to do a little subtraction, if possible.

Accordingly, we rose extra early one January morning—it was the feast of St. Agnes—and set sail in Joseph Ford (Joseph for St. Joseph and Ford for Henry), for the oil field at Khaur. It was beautiful weather, though cold enough, and sunrise across the hills was a sight worth seeing. We drove steadily for 50 miles, when coming over a rise in the ground we saw, three miles away, the oil field studded with derricks (the real professional word is "rigs"), with smoke rising here and there. At this sight we halted Joseph in his career and sat down for a small picnic of two beside a tall rock. We had some canned things from Libby, McNeill and Libby and hot coffee in a thermos bottle, and we said among ourselves, what grand people the Americans are to think up all these things—cans and such.

Neither of us had had any experience of begging, but we forecast that *it* would not be a picnic, at any rate. However, encouraged by the coffee, the beautiful morning and the thought of St. Joseph we descended upon Khaur and found the manager. He was not enthusiastic about our project, but gave us a letter to the foreman of the drillers—an American Catholic and a very pleasant man, who did all in his power to help us that day. He told us that the men worked in three shifts of eight hours each. So we made haste to travel about in the Ford to catch second shift before 12 o'clock. After 12 and luncheon at the home of the foreman we started in all over again and by evening the men for the night shift were up and these we found in their homes.

I think we will never forget the experience of that day—climbing in and out of the oily and slippery rigs amid the roar and chug of the machinery, seeing here a drill being changed and there lengths of pipe getting threaded together and lowered down the holes; some of the holes, by the way were nearly a mile deep. Each rig contained one white man and six or eight Indians. In some they were only boring and had not yet struck oil and knew not whether they ever would, in some the oil was flowing and in one, I think, a great length of pipe had been lost and was being fished for, though I am not sure if we saw this in process.



Dr. Lyons starting out on her six-mile walk to get first aid for Joseph Ford, temporarily paralyzed

Between times we interviewed the engineers, in their department. One we found in the power house. He had two huge dynamos going and seemed to be tuning in a third. Khaur is an interesting study in nationalities; the manager and the engineers are Scotch, the clerks in the offices Indians, and the men who, with the assistance of some Indian helpers, actually drill the wells are Americans.

As for us, we went round and round until we had told our story to every white man in the place but one, I think. Nearly every person we met was most friendly and kind. Meeting many of the wives of the drillers, we were all glad to exchange a word about Home. (You write it with a capital letter out here.)

It struck us, going about what a hard life these drillers have, though they are well paid and have good houses to live in. Eight hours a day, seven days a week, they work. There is no church or school in the place, no movie either. The only amusement available is golf, except when an occasional trip to Rawalpindi is made. A trying life for the body and more so for the spirit.

Evening drew on. We wanted to get home and so declined a kind and pressing invitation to dinner. Turning in our subscription list, we set the nose of Joseph Ford for home. A little way out we stopped to finish off the rest of the coffee in the thermos flasks (still fairly hot) and to finish what was left of the morning's picnic. We would be home at bedtime, we thought as we started Joseph. But horrors, he would not start. He had been coughing a bit during the day but the expert drivers in Khaur said it was only a passing indisposition. It began to be late. We decided it would be better to push the car up into a side road, hoping that no one would find and dismantle it, and return to Khaur for the night. Then came along two good Samaritans driving a truck. They were young boys, a Mohammedan and a Sikh. We flagged them with a flashlight and they descended and they poked a bit at Joseph Ford and found that there was an obstruction in the gasoline as it came down from the tank. This being cleared away, our ears were gladdened by the pleasant sound of the motor purring contentedly. Still we did not trust it to go to Rawalpindi but we returned to Khaur and established ourselves in the Dak bungalow for the night. In the morning, said we, we will slip away and our good friends in Khaur will never know. Morning came and the man who takes care of the Dak bungalow produced for breakfast a pot of something he called tea and four hard boiled eggs. We ate and set off at once.

It was a glorious morning.

(Cont'd on p. 7)